ILHIE ILLINOIS HEALTH INFORMATION EXCHANGE

ILHIE Direct Secure Messaging System
TEMPLATE CONSENT FORM PROVIDER SCRIPT

According to Federal and State law, your patients must be fully informed when agreeing to sign the enclosed Illinois Health Information Exchange ("ILHIE") Direct Secure Messaging System Consent Form (the "Consent Form"). You should take the time to go through each step of the Consent Form and assist patients with completing the Consent Form and answering any questions they may have. Below are ideas for how you may explain the Consent Form to your patients.

Introductory Comments to Patient

- ILHIE has created a direct, secure, encrypted, electronic messaging service (called "ILHIE Direct") that supports secure electronic communication between health care providers. ILHIE Direct is designed to help providers easily and securely share information such as referrals, patient summaries and lab results to enhance patient care.
- By signing this form it will help your doctors and treatment providers improve your quality of care by better coordinating your care.
- Signing this form is your choice. It's your decision to determine who receives your information.
- Let's go through the form together.

Purpose of Consent Form

- There are federal and state laws which protect the confidentiality of your information.
- If you agree to sign the Consent Form, the health information you release will be used for your treatment and coordination of care by your other health care providers who are using a secure messaging system called ILHIE Direct, and for the improvement of our and your other providOctober 30, 201210/30/2012ers' health care operations.
- You should also understand that we, as your health care provider, will not condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this Consent Form.

Patient Information

- To use ILHIE Direct for your treatment and coordination of your care, we must be able to identify you.
- Please fill in your full name, address, telephone number, e-mail address, and date of birth in the box at the top of the Consent Form.

Who May Disclose

- The next section of the Consent Form asks you to specify which of your providers can share your health information.
- In this case, you would indicate that we, as your provider, would be permitted to release your health information. Please list ***[INSERT PROVIDER'S FULL NAME]*** in the space provided.

What May Be Disclosed

- The Consent Form automatically lets us disclose all of your health information, including your medications, immunizations, problems and diagnoses, demographic information, allergies, lab results, social history, psychiatric evaluations, care plan, health care providers, presence and participation in substance abuse treatment or mental health services, HIV and genetic testing results.
- The reason for this is because sharing all of your health information with other providers who treat you in the future will allow them to maximize the quality of care you receive.
- However, if you want to somehow limit the information we can disclose to your other providers, you can do so in the space provided.

Who May Receive

- The next section of the Consent Form asks you to specify who we can release your health information to. Please list the names of the providers who you want to receive your health information on the lines provided.

Purposes

- This section describes the reasons why your health information can be shared.
- You can choose: for your treatment, to coordinate your care among your providers, to improve your provider's health care operations, or all of the above.
- Please indicate your choice by checking the boxes next to the purposes you authorize.

Expiration

- The Consent Form is automatically set to expire one year from today.
- However, you can choose for the Consent Form to expire sooner by writing in the date on which you want the Consent Form to expire on the line provided.

Revocation

- You have the right to revoke this consent which means we would stop sharing the information with others.
- However, if we have already disclosed your medical records to others, we cannot recall those medical records or the health information disclosed. No new records will be disclosed after the date you revoke this Consent Form.
- If you wish to revoke this Consent Form at any time, just let us know.

Inspection

- You should also understand that you have the right to inspect and copy any of your health information. If you wish to do so, please contact us.

Federal Law

- The health information disclosed by this Consent Form may be records protected by 42 C.F.R. Part 2, which is a Federal law governing the confidentiality of substance abuse treatment records.
- This law prevents the providers who received your health information from disclosing your records again.
- This Federal law also restricts the use of information released pursuant to this Consent Form to criminally investigate or prosecute you.

Signature

- The last thing for you to do is to sign the Consent Form. Please do so on the line provided. We may request that your parent, guardian or personal representative sign the Consent Form on your behalf. Please also write in today's date on the line next to the signature.

Prepared by Popovits & Robinson, P.C.
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